BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	)	
DIRK HENDRIK VAN MEURS, M.D.	)	Case No. 8002014005883
Physician's and Surgeon's Certificate No. G 40574	)	
Respondent.	)	

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by John M. Latini, Esq., on behalf of Dirk Hendrik Van Meurs, M.D., and the time for action having expired at 5 p.m. on January 22, 2018, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	)	
	)	MBC No. 8002014005883
DIRK HENDRIK VAN MEURS, M.D.	)	
Physician's and Surgeon's Certificate No. G 40574	)	**ORDER GRANTING STAY**
	)	(Government Code Section 11521)
Petitioner	)	

John M. Latini, Esq., on behalf of respondent, Dirk Hendrik Van Meurs, M.D., has filed a Request for Stay of execution of the Decision in this matter with an effective date of January 12, 2018, at 5:00 p.m.

Execution is stayed until January 22, 2018.

This stay is granted solely for the purpose of allowing the Board to review and consider the Petition for Reconsideration.

DATED: January 12, 2018

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against:	)	
DIRK HENDRIK VAN MEURS, M.D.	)	Case No. 8002014005883
Physician's and Surgeon's Certificate No. G 40574	)	
Respondent	)	

DECISION AND ORDER

The attached Proposed Decision is hereby amended, pursuant to Government Code section 11517(c)(2)(C) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Page 14, Paragraph No. 24, the first sentence is corrected to read "Respondent is 67 years old."

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 12, 2018.

IT IS SO ORDERED December 15, 2017.

MEDICAL BOARD OF CALIFORNIA

By: Kristina Lawson

Kristina D. Lawson, J.D., Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: DIRK HENDRIK VAN MEURS, M.D., Physician and Surgeon Certificate No. G40574 Respondent.	OAH No. 2017060696 Case No. 8002014005883

PROPOSED DECISION

This matter was heard before Erin R. Koch-Goodman, Administrative Law Judge, Office of Administrative Hearings, State of California, on October 16 and 17, 2017, in Sacramento, California.

David Carr, Deputy Attorney General, represented Kimberly Kirchmeyer (complainant), Executive Director, Medical Board of California (Board), Department of Consumer Affairs.

John Latini, Attorney at Law, represented Dirk Hendrik Van Meurs, M.D. (respondent), who was present at hearing.

Evidence was received, the record was closed, and the matter was submitted for decision on October 17, 2017.

FACTUAL FINDINGS

1. On August 13, 1979, the Board issued Physician and Surgeon Certificate License No. G40574 to respondent. The license will expire on June 30, 2019, unless renewed.

2. On September 20, 2016, complainant, in her official capacity, made and served the Accusation and Petition to Revoke Probation against respondent, alleging

respondent committed gross negligence in his care and treatment of Patients KC, DG, CM, MC, BC, DV, and violated Probation Condition 7[1] to obey all rules governing the practice of medicine. More specifically, respondent: (1) failed to conduct a physical examination before prescribing dangerous drugs to Patients KC, DG, CM, MC, and DV; (2) failed to obtain informed consent prior to prescribing controlled substances from Patients KC, DG, CM, MC, and BC; (3) failed to document review of unanswered questions on the substance abuse history questionnaire for Patient BC; (4) prescribed large amounts of opioids to Patient DG; (5) prescribed opioids with benzodiazepines, Phenergan, Soma, Klonopin, Ambien, and Sinemet, or a combination thereof, to Patients DG, MC, BC, and DV, without documenting a clinical indication or rationale; (6) simultaneously prescribed multiple benzodiazepines to Patient CM; (7) failed to respond to signs of controlled substance misuse/abuse in Patients CM and MC; and (8) failed to maintain adequate and accurate records for Patients KC, DG, CM, BC, and DV.

3. Respondent appealed. An evidentiary hearing followed, conducted before an administrative law judge, pursuant to Government Code section 11505.

Accusation

BOARD EXPERT – ROBERT M. FRANKLIN, M.D., FAMILY MEDICINE

4. Dr. Franklin completed his Bachelor of Art in zoology in 1986 at the University of California, Berkeley, before earning his Medical Degree in 1990 at George Washington University, Washington D.C. Dr. Franklin then completed a three-year residency in family medicine at the University of California, San Francisco. In 1991, he became licensed to practice medicine in California. He is Board Certified by the American Board of Family Practice. Currently, Dr. Franklin is an emergency department physician at Kaiser Hospital in South San Francisco and a family physician at Southeast Health Center in San Francisco. He has served as a medical expert for the American Medical Forensic Specialists since 2009, and for the Board since 2003.

5. The Board retained Dr. Franklin to conduct a review of documents and provide an opinion on whether respondent acted within the medical standard of care when he treated Patients KC, DG, CM, MC, BC, and DV, while employed by Del Norte Clinics, renamed Ampla Health, from October 2010, through October 2012. The Board provided Dr. Franklin with the following documents for his review: Board Investigative Report; medical records and prescription records for Patient KC, DG, CM, MC, BC, and DV; and audio and transcript of respondent's interview with Board. Dr. Franklin reviewed the document and wrote a Report, dated May 4, 2015. The parties stipulated to the admission of Dr. Franklin's Report, and Dr. Franklin was excused from testifying.

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[1] The First Amended Accusation incorrectly identifies the Obey All Laws probationary condition as 8.

6. Dr. Franklin found more than 118 extreme departures from the standard of care relative to respondent's care and treatment of Patients KC, DG, CM, MC, BC, and DV: 7 for Patient KC, 16 for Patient DG, 12 for Patient CM, 37 for Patient MC, 26 for Patient BC, and 20 for Patient DV. Dr. Franklin evaluated respondent in four areas: the evaluation and management of chronic pain; the evaluation and management of medical conditions; diagnosis and treatment of psychiatric conditions in primary care; and prescribing multiple medications.

7. First, Dr. Franklin focused on the evaluation and management of chronic pain. Dr. Franklin provided the following standard of care.

> The standard of medical practice in California regarding the treatment of chronic intractable nonmalignant pain (CINP) with opioid medication is defined by a combination of state law, federal law, and community standards of practice; it applies to the treatment of pain not due to malignancy, not given in the context of end-of-life or hospice care, and not given in the context of a painful condition that is expected to resolve.
>
> In the setting of a primary care office or pain treatment clinic, it is the standard of practice to perform a comprehensive medical history and physical examination. In particular: 'this includes an assessment of the pain, physical and psychological function; a substance abuse history; history of pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.
>
> It is the standard of practice that a treatment plan with specific, objective goals be documented in the patient's chart. The plan should include specific details of a plan of action in the face of either future improvement or deterioration. It should not be limited only to pharmacological intervention. Such indicators as quality of life, control of pain, and level of function are often used to measure progress in reaching the goals of the treatment plan. When inconsistencies are identified between the patient's history and objective evidence, it is the standard of practice to document the basis of the clinical decisions regarding continuing, altering, or discontinuing opioid treatment. It is the standard of practice that informed consent be obtained prior to beginning opioid treatment for CINP. The discussion of risks and benefits of opioid treatment should be documented in the chart. It the standard of practice to give that material to the patient both in writing and verbally. Often, a written consent or pain agreement is used as a tool to document that the informed

consent standard was met. It is not required that the patient sign the agreement, to meet the standard of practice.

It is the standard of practice to document periodic reviews of the course of pain treatment, paying particular attention to the improvement, stability, or deterioration of the patient's condition. It is the standard of practice, at a minimum, to document aberrant behavior during these period reviews. Aberrant medication-related behavior that would raise concerns regarding patient drug diversion include: multiple missed appointments, failure to comply with prescription instructions, multiple lost or stolen prescriptions, over-use of prescription medication, and requests for "early" medication refill. It is the standard of practice to consider data learned at each visit and during each systematic periodic review to determine the propriety and effectiveness of current treatment. It is the standard of practice to change therapy in a rational, evidence-based fashion, in response to clinical data. It is the standard of practice to document formal periodic review at least annually.

It is the standard of practice to consider referring the patient as necessary for additional evaluation and treatment. It is the standard of practice for primary care physicians prescribing pain medication to document coordination of care among the various specialists consulting in the patient's care, including especially psychiatrists, psychologists, and pain specialists. It is the reciprocal standard of practice for specialists in Pain Medicine to ensure timely and accurate communication with the primary physician.

It is the standard of practice when treating CINP with opioid medications to pay rigorous attention to medical recordkeeping. 'The physician . . . should keep accurate and complete records . . .including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, rationale for changes in the treatment plan or medications, agreements with the patient, and periodic reviews of the treatment plan.

It is the standard of practice for the physician to recognize that prescription of opiate medications for pain is a potentially dangerous practice that requires the highest attention to detail. The risks include: misuse resulting in abuse, overdose, or withdrawal, drug-drug interactions, and diversion of the opiate medication. For that reason, it is the standard of practice to

prescribe a specific quantity of opiate medication for a specific time period, not to exceed 30 days. It is the standard of practice to be vigilant for "red flags" that may indicate abuse, over-use, or diversion: early refills, lost or stolen medication, failure to follow instructions for use and follow-up, toxicology screens that show the use of un-prescribed medication or fail to show the agent prescribed, and manipulative behavior. Any "red flag" behavior warrants immediate evaluation. Repeated "red flag" behavior warrants taper of opiate medication or referral to a dedicated Pain Clinic.

8. Dr. Franklin found respondent made the following extreme departures from the standard of practice for the evaluation and management of chronic pain for Patients KC, DG, CM, MC, BC, and DV:

a. For Patient KC, respondent: failed to obtain and document a history and physical examination sufficient to support the treatment; diagnosed an anxiety disorder without performing and documenting a detailed social, substance use, psychiatric, and neurological history and physical examination; treated back pain "by history"; diagnosed Restless Leg Syndrome without specific inquiry into, and documentation of, signs and symptoms in a patient with a history of taking antipsychotic medication; failed to obtain and document informed consent for treatment with opioid medication; and failed to document consideration of the potential drug-drug interaction between opiates, Soma, Risperdal, and Klonopin.

b. For Patient DG, respondent: failed to perform and document a thorough history, including a social history and substance abuse history, and physical examination, to support the care and treatment, and failed to integrate the thorough history into the treatment plan; failed to perform and document informed consent for opiate treatment, including a discussion about the use of multiple medications with adverse effects; failed to establish and document objective goals of therapy; increased the dose of OxyContin by 20-percent on second visit without verifying current medication use; treated anxiety with benzodiazepines in a patient taking opioids; prescribed Halcion in addition to opioids and benzodiazepines; and failed to seek out prior medical records and then prescribed opioid medications without prior medical records.

c. For Patient CM, respondent: failed to document a sufficient history and physical examination to support the treatment; failed to perform and document informed consent for treatment of CINP with opiates and anxiety with benzodiazepine; allowed early refills of opiates and

benzodiazepines; prescribed more than one benzodiazepine at a time, as well as prescribed overlapping prescriptions for lorazepam, Klonopin, Restoril, and Ambien; prescribed more than one short-acting opiate to the same patient without clear documentation of the rationale; failed to perform and document a thorough evaluation of neck pain after patient's fall; failed to promptly respond to patient complaint of somnambulism; inaccurately documented patient's use of medication; increased medication by 50-percent for duration, when the intention was to increase for one prescription, as documented in the medical record; increased medication by 150-percent, failing to consider the refill already available; prescribed Restoril without clear documentation of the strength, quantity, and instructions; prescribed Soma, Phenergan, Vistaril, and Robaxin in combination with other opioids; failed to consider and document aberrant drug behavior by patient, including reporting lost medications, and a non-concordant toxicology screen with positive results for methamphetamines; as a result of aberrant behavior, failed to taper or discontinue benzodiazepines and opioid therapy; failed to document a detailed evaluation of anxiety; prescribed large amounts of four different benzodiazepines without seeking a psychiatric consultation; and failed to refer patient for psychotherapy .

d. For Patient MC, respondent: failed to document a sufficient history and physical examination to support the care and treatment; prescribed large quantities of opiate medication; failed to obtain informed consent for opiate medications; failed to make a detailed assessment of patient pain and etiology; failed to document treatment plan with measureable benchmarks; failed to maintain a medication list, including exact number, dosage, and instructions for every medication prescribed; failed to document a thorough spine examination, for a patient under treatment for scoliosis; failed to document a detailed neurological examination; and escalated the dose of opiate treatment without clear documentation; failed to recognize multiple warning signs for possible aberrant drug behavior; failed to recognize emergency room visit for medication-related alteration as a warning sign; and failed to take and document a detailed history of alcohol and substance use.

e. For Patient BC, respondent: failed to document a sufficient history and physical examination to support the care and treatment; prescribed controlled medication without informed consent; failed to make a detailed assessment of patient pain and etiology; failed to document treatment plan with measureable benchmarks; failed to maintain a medication list, including exact number, dosage, and instructions for every medication prescribed; failed to review the Confidential Medical History Form and address the issues of alcohol and substance abuse before prescribing a controlled medication; failed to recognize multiple

warning signs for possible aberrant drug behavior; failed to recognize aberrant drug behavior when she informed respondent she took her daughter's opioid medication; failed to recognize increasing opiate dose by 400-percent over four months was a major change in treatment; failed to recognize increasing the dose of benzodiazepines and providing multiple early refills was a significant and dangerous change; prescribed one and one-half times as much Soma as he directed her to take; over-prescribed Klonopin; and failed to take and document a detailed history of alcohol and substance use.

f. For Patient DV, respondent: failed to document a sufficient history and physical examination to support the care and treatment; prescribed controlled medication without informed consent; failed to make a detailed assessment of patient pain and etiology; failed to document treatment plan with measureable benchmarks; failed to maintain a medication list, including exact number, dosage, and instructions for every medication prescribed; failed to recognize multiple warning signs for possible aberrant drug behavior; failed to recognize ongoing substance abuse and aberrant drug behavior, especially knowing of prior abuse of methamphetamines; and failed to take and document a detailed history of alcohol and substance use.

9. Second, Dr. Franklin focused on the evaluation and management of medical conditions. Dr. Franklin provided the standard of practice in California to include: carefully evaluate each presenting complaint, giving consideration to differential diagnosis and specific treatment; perform and document sufficient history, physical examination, and laboratory studies to confirm diagnosis, exclude more serious pathology, and ensure that the treatment is safe and effective; identify and act upon serious or emergent conditions at any opportunity; carefully evaluate each presenting complaint, giving consideration to differential diagnosis and specific treatment; be alert to serious pathology in their patients and to provide appropriate care or referral to appropriate care for those patients who present with evidence of serious conditions (e.g., medical or psychiatric); and perform and document sufficient history, physical examination, and laboratory studies to confirm the diagnosis and exclude more serious pathology.

10. Dr. Franklin found respondent made the following extreme departures from the standard of practice for the evaluation and management of medical conditions for Patient DG. Respondent failed to document a complete history and physical examination; failed to document and perform an adequate neurological history and physical examination; failed to determine the etiology of her syncope episode during her visit, and take immediate steps to treat the etiology; failed to evaluate, or refer her for evaluation and treatment of possible bleeding disorder or blood dyscrasia, thereby exposing her to the risk of serious bleeding; diagnosed sinusitis without preforming an adequate history and physical examination; and prescribed amoxicillin, knowing about her allergy to penicillin, without clear documentation as to why the amoxicillin was preferred over other agents.

11. Third, Dr. Franklin focused on the evaluation and management of psychiatric conditions. Dr. Franklin provided the following standard of care:

> As with medical problems, the standard of medical practice in California regarding the evaluation and management of psychiatric problems is to carefully evaluate each presenting complaint, giving consideration to differential diagnosis and specific treatment. It is the standard of practice to perform and document sufficient history, physical examination, and laboratory studies to confirm the diagnosis, exclude more serious pathology, and ensure that the treatment is safe and effective. It is the standard of practice to make specific diagnosis in accordance with recognized definitions.
>
> Because psychiatric diseases often lack specific and sensitive physical findings, a detailed history is of critical importance in making accurate psychiatric diagnosis and in monitoring response to treatment. Most commonly, formal tools are used for that purpose. For example, in depression, it is common to use the PHQ-9 or another formal assessment scale both before and during treatment. Adult Attention Deficit Hyperactivity Disorder [ADHD] is a difficult diagnosis to make and confirm. It has substantial overlap with other disorders and in particular overlaps with the symptoms of stimulant drug abuse. For that reason, it is critically important to use validated screening tools when considering the diagnosis of [Attention Deficit Disorder] ADD or ADHD in adults. Similarly, bipolar disorder requires detailed history and careful attention to the possibility of stimulant drug abuse being used to self-medicate underlying depression. The management of psychotic disorders in primary care is particularly challenging because history is both critically important to obtain and often highly variable from visit to visit.
>
> In many patients undergoing treatment for chronic pain, mental health disorders coexist. Successfully treating underlying mental health disorders requires a high level of skill and caution. Most commonly, pharmacological management of such patients in a primary care setting cannot be done safely without psychiatric consultation. When that management is undertaken by the primary care physician, frequent visits are the norm and careful documentation is required. Psychiatrists and therapists typically spend thirty to sixty minutes with each patient and commonly see their patients as often as weekly. If a primary care physician opts to be a primary physician managing mental health disorders, then the same requirement apply to that

physician as apply to psychiatrists managing the same conditions. For that reason, it is common for primary care physicians to screen for mental health disorders, treat only a limited spectrum of psychiatric disease, and refer complicated patients for management by experienced specialists.

If a primary care physician chooses to manage patients with complex mental health problems without consultation, it is incumbent on that physician to attain and maintain a high level of diagnostic and therapeutic skill.

12. Dr. Franklin found respondent made the following extreme departures from the standard of practice for the evaluation and management of psychiatric conditions for Patients MC, BC, and DV:

a. For Patient MC, respondent: diagnosed depression, anxiety, bipolar disorder, and ADHD without documenting an adequate history and physical examination; prescribed lithium, Stattera, Symbyax, Cymbalta, methylphenidate, and Adderall to treat depression, anxiety, bipolar disorder, and ADHD; failed to document an evaluation for suicidal ideations; prescribed both fluoxetine and duloxetine simultaneously; prescribed methylphenidate without documenting a plan to avoid the adverse effects outlined in the Black Box warning; failed to take steps to prevent adverse effects of discontinuing methylphenidate; substituted Adderall for methylphenidate without documentation of plan for safe substitution; and failed to take substance abuse history prior to prescribing methylphenidate or Adderall.

b. For Patient BC, respondent: prescribed Abilify, Zyprexa, Zoloft, and Remeron without documentation; failed to document an evaluation for suicidal ideations; and failed to document a detailed psychiatric and neurological history and physical examination before prescribing benzodiazepines.

c. For Patient DV, respondent: diagnosed depression and bipolar disorder without documenting an adequate history and physical examination; failed to exclude active substance abuse disorder, given her admitted history of methamphetamine and alcohol abuse, before treating her for other non-emergent conditions; failed to document an evaluation for suicidal ideations; and prescribed Abilify without documenting an evaluation for suicidal ideations or a diagnosis.

13. Fourth, Dr. Franklin focused on the prescription of multiple medications. Dr. Franklin provided the following standard of care:

The standard of medication practice in California is to exercise due caution and good clinical judgement when prescribing potentially-dangerous medications, particularly when they are given in combination. It is the standard of practice for physicians to be aware of the adverse effects of the drugs they prescribe and be aware of how they may interact with other medications they prescribe. The standard of practice is to consider the risk of intentional and unintentional overdose when prescribing opioid medication.

14. Dr. Franklin found respondent made the following extreme departures from the standard of practice for prescribing multiple medications for Patients DG, MC, BC, and DV:

a. For Patient DG, respondent: prescribed Valium, morphine, promethazine, hydroxyzine, amitriptyline, Gabapentin, Halcion, Tagamet, along with large doses of OxyContin; increased morphine from 60 to 120 mg per day; and failed to react to the pharmacy warning. Dr. Franklin found respondent made the following simple departure from the standard of care: prescribed Tagamet without sufficient documentation in the medical record to support that decision.

b. For Patient MC, respondent: prescribed two long-acting opioid medications; prescribed short-acting opiate with Soma; failed to document an informed consent discussion; prescribed benzodiazepines, Phenergan, Abilify, lithium, methylphenidate, Strattera, fluoxetine, duloxetine, olanzapine, and Soma with opiate medications; failed to document absence of suicidal ideations with fluoxetine, duloxetine, and Strattera prescribed; and failed to obtain EKG and document consideration of QT prolongation when prescribing multiple medications with that side effect.

c. For Patient BC, respondent: prescribed long-acting opiates without determining she was opiate tolerant; prescribed Soma, Klonopin, Ambien, Phenergan with codeine, and azithromycin, with opiate and benzodiazepine medications; and prescribed Sinemet off-label without documenting the indication and rationale and informed consent.

d. For Patient DV, respondent: prescribed Donnatal, Phenergan and Phenergan with codeine, Soma, and Zoloft, with opiate and benzodiazepine medications; prescribed more than the minimum amount of Valium necessary to sedate the patient for an abdominal ultrasound; and prescribed two long-acting benzodiazepines without clear documentation of rationale for treatment.

15. In sum, Dr. Franklin found respondent to be unfit to practice medicine. He opined:

> The collection of extreme departures from the standard of practice found in Dr. Van Meurs' treatment of [Patient DG] is extraordinary. Apparently without any hesitation or consideration, he undertook to treat her with enormous doses of OxyContin, in a pattern that he himself described in the medical record as "ridiculous" and "crazy." He compounded that egregious error with dangerous polypharmacy, exposing this patient to very real risk of death or serious injury. When she passed out and fell from the toilet, striking her head, he documents that she has "no problem" with the medication regimen. When given a warning about a potentially serious drug-drug interaction by the pharmacy, he ignored it for a month. His practice pattern in this case is indicative of a reckless disregard for his patient's safety. A physician who manifests such reckless disregard and is so arrogant as to continue to prescribe in an accurately self-described "ridiculous" pattern, is manifestly unfit to practice medicine in the State of California.
>
> Dr. Van Meurs also prescribed with reckless disregard of patient safety [in the] case of [Patient CM] as well. While he does not self-describe his prescription patterns in this case as "ridiculous" or "crazy," they are nonetheless manifestly irrational and self-contradictory. They are dangerous. They depart in such extreme fashion from the standard of practice that they are prima facie evidence that Dr. Van Meurs is unfit to practice medicine in the State of California.
>
> Similarly, Dr. Van Meurs' practice patterns with [Patients MC, BC, and DV] are irrational and contradictory. He diagnoses [Patient MC] with "early pyelonephritis" without taking a relevant history or performing a relevant physical examination. He then escalates her "impressive" medication regimen without rational justification. When RPH Ken Harlan describes Dr. Van Meurs' prescription pattern as "irrational," he is precisely correct. That irrationality is demonstrated in the interview discussion of Dr. Van Meurs' prescriptions to [Patient BC]. Dr. Van Meurs refers to a quadrupling of opiate dose and a massive over prescription of Soma and Klonopin as a "small adjustment." That irrationality is demonstrated again in Dr. Van Meurs' simultaneous prescription of benzodiazepines and stimulants to [Patient DV].

When he undertook to prescribe Valium to [Patient DV], he was already prescribing to her a toxic brew of opiates, Soma, and Phenergan. Yet he prescribed her Valium anyway, as an experiment in sedation. That experimental prescription morphed into a standing prescription for Valium, which is then changed to a standing prescription for Klonopin, another long-acting benzodiazepine, with no comment in the medical record. The lack of documentation of a clinical rationale to prescribe a toxic and habit forming medication, a medication that Dr. Van Meurs avows to dislike and the use of which he thinks should be minimized, indicates a failure of clinical judgement that appears to be pervasive in Dr. Van Meurs' practice of medicine.

Dr. Van Meurs acknowledges that he is incompetent to diagnose various psychiatric illnesses. Yet he undertook to treat those illnesses in the patients whose records were reviewed for this report. Dr. Van Meurs states: "I like to try to minimize medications to the extent possible just because the interaction issues are hard to predict." Yet much of this review is a delineation of the extraordinary extent to which Dr. Van Meurs prescribes enormous quantities of toxic medications and multiple medications with known, predictable dangerous interactions, all without clearly documented reasons to do so. Dr. Van Meurs is a physician who knows he cannot diagnose and treat [psychiatric conditions], but does precisely that. He is a physician who purports to understand how dangerous excessive prescribing can be, yet prescribes excessively at every turn. It is impossible to fathom how he can do those things and yet continue to practice medicine in California.

I regard the continued practice of medicine by Dr. Van Meurs as a clear and present danger to public health and safety.

Petition to Revoke Probation

PRIOR DISCIPLINE

16. On October 15, 2007, the Board issued a Decision and Order, Case No. 12-2005-164954, against respondent, revoking his Physician and Surgeon's Certificate. The revocation was stayed and respondent was placed on probation for five years, with terms and conditions. The Decision and Order found respondent negligently prescribed controlled substances to 13 patients.

17. On July 19, 2010, the Board issued a Decision and Order, Case No. D1-2005-164594, against respondent, suspending his Physician and Surgeon Certificate for 30 days,

and extending his probation for three additional years. The Decision and Order found respondent violated the terms and conditions of probation by failing to complete required continuing medical education courses or pay probationary monitoring costs.

COMPLIANCE WITH PROBATIONARY TERMS

18. On July 20, 2010, Inspector Arlene Caballero conducted an intake interview with respondent. During the interview, each condition of probation was reviewed with respondent, including Conditions 2 - Practice Monitor, 3 - Controlled Substances: Maintain Records and Access to Records and Inventories, 4 – Education Course, 7 – Obey All Laws, 8 – Quarterly Declarations, and 16 – Probation Monitoring Costs. Both Inspector Caballero and respondent signed an Acknowledgement of Decision form, indicating that the Decision and Order was explained to respondent and that he understood all the terms and conditions of probation.

19. From October 2010, to October 2012, respondent was practicing with Del Norte Clinics, renamed Ampla Health. He was unemployed until August 2013, when he was hired by Sacramento Family Medical Group (SFMG). Respondent worked at SFMG until he received a Cease Practice Order by the Board on June 17, 2017. When respondent was not practicing, his probationary period tolled. In total, respondent has been on probation for nearly 10 years.

20. On June 14, 2014, the instant Accusation and Petition to Revoke Probation was filed. The First Amended Accusation and Petition to Revoke Probation was filed on September 20, 2016.

21. On July 20, 2015, respondent informed the Board his practice monitor had left SFMG. On July 21, 2015, Inspector Cassie Davis informed respondent a new practice monitor would have to be submitted to the Board no later than August 21, 2015. On August 20, 2015, Inspector Davis made an unannounced visit to respondent's place of employment. Inspector Davis spoke to respondent and asked for respondent's controlled substance logs; respondent was unable to produce the logs. On September 4, 2015, Inspector Davis wrote respondent a letter, indicating respondent was not in compliance with his probation terms and conditions, including controlled substances logs, a practice monitor, and quarterly reports. In addition, Inspector Davis told respondent a practice monitor was required by October 10, 2015. Hearing nothing, on October 27, 2015, Inspector Davis sent respondent another letter, giving him until November 6, 2015, to find a practice monitor.

22. On February 9, 2016, the case was reassigned to Inspector Bryan Joelson. On June 3, 2016, and October 21, 2016, Inspector Joelson left voicemail messages for respondent requesting a return call to schedule a quarterly interview; respondent failed to return either call. Also on October 21, 2016, Inspector Joelson wrote a letter to respondent, requesting respondent telephone to schedule a quarterly meeting. Inspector Joelson hand delivered his letter to respondent, when he made an unannounced visit to respondent's place of employment, the same day. During the visit, Inspector Joelson requested respondent's

controlled substances logs; respondent indicated he had not maintained any controlled substances logs. Inspector Joelson also asked respondent if he currently had a practice monitor in place; respondent indicated he did not have a practice monitor. Inspector Joelson then informed respondent he had not received quarterly reports for 2015, third and fourth quarter, and 2016, second and third quarter, and requested respondent submit the reports immediately. To follow-up, on October 24, 2016, Inspector Joelson sent respondent an email with deadlines for compliance: nominate a practice monitor or enroll in the Physician Assessment and Clinical Education (PACE) monitoring Physician Enhanced Program (PEP) by October 28, 2016; going forward, maintain controlled substances logs, and produce controlled substance logs for the last six months by November 4, 2016; submit a detailed proposal explaining your plan for completing 110 continuing medical education (CME) units, for 2014 and 2015, by November 1, 2016; submit the four missing quarterly reports by October 28, 2016; and contact the Board to establish a payment plan to submit $2,186 for 2014 probation monitoring costs and $4,106 for 2015 probation monitoring costs. On October 31, 2016, Inspector sent respondent another email, asking him to confirm receipt of his October 24, 2016, email. Respondent replied stating: "battling back pain and a viral syndrome all last week." On November 7, 2016, respondent sent an email to Inspector Joelson, indicating: (1) he was most concerned about finding an attorney for the Accusation and Petition to Revoke Probation; (2) he is constrained in his responses to the Board because of his 14 hour workdays; and (3) he is in the midst of filing bankruptcy and has "virtually no money available." On November 18, 2016, Inspector Joelson sent respondent another email, advising respondent that he had failed to meet all deadlines, and now, a probation monitor, his controlled substances logs, all outstanding quarterly reports, and a plan for completing CME units were due by November 28, 2016. As of February 27, 2017, respondent failed to comply with all deadlines. On June 17, 2017, the Board issued and served a Cease Practice Order on respondent.

PROBATIONARY TERM AT ISSUE

23. Condition 7, states:

> Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

Respondent's Testimony

24. Respondent is 48 years old. He is married and lives in Albany with his wife. Currently, respondent is not practicing because the Board issued a Cease Practice Order on June 17, 2017, for failure to comply with probationary terms, including having a practice monitor.

25. Respondent has been confused about his obligations under the Board's probationary terms. He believes he has not heard from the Board on a consistent basis to

assist him. He does not believe he has been on probation for nearly ten years. He remembers the 2007 Accusation and the resulting 30 day suspension with probationary terms. He has tried to meet all terms and conditions of probation, but he has consistently had financial troubles, precluding him from paying the Board for monitoring costs, as well as taking requiring CME coursework. In addition, after his probation monitor left in 2015, respondent submitted multiple names to the Board for approval, but the Board rejected all of them. He was engaging PEP, at a great personal expense, when the Board issued the Cease Practice Order. Respondent was "shocked" by the Order.

26. Respondent described all of his practice environments to be busy clinics, mostly understaffed, with no internal resources for chronic pain management patients. At the start of his career, pain management and the prescription of opioids for pain were not topics of general discussion. In the 1990s, things changed and CME classes were offered on pain management and prescribing opioids for pain; respondent attended some. More recently, respondent has taken CME classes on pain management, the over-prescribing of opioids, and alternative treatments for chronic pain patients. In addition, respondent has attended the PACE program in San Diego. As a result of all of the coursework, respondent has changed his prescribing practices and prescribes fewer opioid medications in his current practice. He now knows chronic pain patients need to be seen for follow-ups within two months. But at a clinic, quick follow-up appointments are scarce, so he now explores alternative modalities to opioid medications as his first treatment option.

Discussion

ACCUSATION

27. Dr. Franklin offered the only medical opinion in this matter; and, he has the qualifications, knowledge, and skill to render said opinion. Further, his Report offers a comprehensive evaluation of respondent's care and treatment of six patients. Dr. Franklin identifies the standard of care, provides a survey of the medical records, applies the standard of care to respondent's care and treatment of each patient, and then offers a conclusion and opinion. In sum, Dr. Franklin found respondent's care and treatment of Patients KC, DG, CM, MC, BC, and DV involved over 118 extreme departures from the standard of care.

PETITION TO REVOKE PROBATION

28. Given the above, respondent violated probationary Condition 7, by failing to comply with all rules governing the practice of medicine in California. Effective July 19, 2010, respondent became subject to probationary terms and conditions detailed in the Decision and Order, Case No. D1-2005-164954, including Condition 7. On July 20, 2010, respondent signed an Acknowledgement, indicating his understanding of the terms and conditions required of him to practice medicine in California. As such, respondent's license was under heightened scrutiny for the term of probation, and he knew it. Even still, respondent carelessly violated several terms and conditions of probation and provided excuses to the Board for his behavior. Respondent is an adult. He is an educated and

licensed professional. His behavior while on probation was wholly inconsistent with his obligations as a license holder.

LEGAL CONCLUSIONS

Accusation

1. To discipline respondent's license, complainant must prove cause for disciplinary action by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 855-856.)

2. Business and Professions Code section 2234 requires the Board to "take action against any licensee who is charged with unprofessional conduct." Unprofessional conduct includes, but is not limited to: gross negligence (Bus. & Prof. Code, § 2234, subd. (b)); "prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication" (Bus. & Prof. Code, § 2242, subd. (a)); and "failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients" (Bus. & Prof. Code, § 2266).

3. Cause exists to discipline respondent's license, under Business and Professions Code sections 2234, 2242, and 2266 in that: he committed gross negligence in his care and treatment of six patients; over prescribed controlled substances to six patients; and failed to maintain adequate and accurate medical records for six patients (Factual Findings 4 through 15).

Petition to Revoke Probation

4. Effective July 19, 2010, respondent became subject to the probationary terms and conditions detailed in the Decision and Order, Case No. D1-2005-164594, including Condition 7, which states:

> Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Based on the matters set forth in Factual Findings 4 through 28, respondent violated the Board's Decision and Order, Condition 7 – Obey All Laws, when he failed to obey all rules governing the practice of medicine in California, by, among other things, committing gross negligence, over-prescribing controlled substances, and failing to maintain adequate and accurate medical records in his care and treatment of six patients.

6. Given all of the above, respondent is not safe to practice medicine in California at this time.

ORDER

Physician's and Surgeon's Certificate No. G 40574 issued to respondent Dirk Hendrik Van Meurs, M.D. is REVOKED.

Dated: November 13, 2017

DocuSigned by:
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ERIN R. KOCH-GOODMAN
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation and Petition to Revoke Probation Against: **DIRK HENDRIK VAN MEURS, M.D.** P.O. Box 6494 Albany, CA 94706 Physician's and Surgeon's Certificate No. G40574 Respondent.	Case No. 8002014005883 **FIRST AMENDED ACCUSATION AND PETITION TO REVOKE PROBATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this First Amended Accusation and Petition to Revoke Probation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On August 13, 1979, the Medical Board of California issued Physician and Surgeon's Certificate Number G40574 to Dirk Hendrik Van Meurs, M.D. ("Respondent"). The Physician's and Surgeon's Certificate will expire on June 30, 2017, unless renewed.

3. In a disciplinary action entitled "In the Matter of Accusation Against Dirk Hendrik Van Meurs, M.D.," Case No. 12 2005 164954, the Medical Board of California issued a decision,

effective October 15, 2007, in which Respondent's Physician's and Surgeon's certificate was revoked. The revocation was stayed and Respondent's Physician's and Surgeon's certificate was placed on probation for a period of five (5) years with certain terms and conditions. The unprofessional conduct which formed the factual basis for this discipline primarily involved negligent prescribing to 13 patients.

4. By a second decision, effective July 19, 2010, Respondent was found to be in violation of his terms of probation in probation case D1-2005-164594, in that he had not completed the required clinical education course within the specified period of time and he had failed to make timely payment of probation monitoring costs. Respondent's probation was continued for three (3) years, his certificate was suspended for 30 days, and all the original terms of his probation continued. A copy of that decision is attached as Exhibit A and is incorporated by reference. By application of Condition 12 of that probationary order, Respondent's period of probation was tolled during an extended period of non-practice and he continues on probation as of this date.

5. On June 13, 2014, an Accusation and Petition to Revoke Probation was filed against Respondent subsequent to the investigation of new allegations in Medical Board Case No. 800-2014-005883.

JURISDICTION

6. This First Amended Accusation and Petition to Revoke Probation is brought before the Medical Board of California ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

7. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

8. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a

reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview scheduled by the mutual agreement of the certificate holder and the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

9. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

10. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. All of the patient treatment and care rendered by Respondent as described herein occurred in California.

DRUGS PRESCRIBED

12. **Ambien**, a trade name for zolpidem tartrate, is a non-benzodiazepine hypnotic of the imidasopyridine class. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is indicated for the short-term treatment of insomnia. It is a central nervous system depressant and should be used cautiously in combination with other central nervous system depressants. Any central nervous system depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

13. **Ativan** is a trade name for the generic lorazepam, a drug of the benzodiazepine group used for anxiety and sedation in the management of anxiety disorder for short-term relief from the

symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

14. **Busiprone** is a non-barbituate anxiolytic psychotropic medication used to treat generalized anxiety. It is a dangerous drug as defined in section 4022.

15. **Klonopin** is a trade name for **clonazepam**, an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system ("CNS") depressant drugs. Like other benzodiazapines, it can produce psychological and physical dependence.

16. **Restoril** is the trade name for the hypnotic agent temazepam. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code.

17. **Percocet**, a trade name for a combination of oxycodone hydrochloride and acetaminophen, is a semisynthetic narcotic analgesic with multiple actions qualitatively similar to those of morphine, a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1)(N) of the Health and Safety Code.

18. **Oxycontin** is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from the opium alkaloid, thebaine. Oxycodone is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code.

19. **Hydrocodone** w/APAP (hydrocodone with acetaminophen) tablets are produced by several drug manufacturers under trade names such as **Vicodin** and **Norco**. Hydrocodone bitartrate is semisynthetic narcotic analgesic, a dangerous drug as defined in section 4022 and a Schedule III controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code.

20. **Halcion** is a trade name for triazolam, a hypnotic drug indicated for the short-term treatment of insomnia. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

21. **Kadian** is a trade name for extended release morphine sulfate, an opioid used in treating severe pain. Kadian is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11056, subdivision (e) of the Health and Safety Code. Like other opioid drugs, Kadian presents a high risk of respiratory depression, abuse, and addiction, most particularly when taken in combination with other opioids, benzodiazepines, or alcohol.

22. **Methylphenidate hydrochloride** is a CNS stimulant indicated for the treatment of attention deficit hyperactivity disorder. Methylphenidate should be given cautiously to patients with a history of drug dependence or alcoholism. Chronic abuse use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior. Methylphenidate is a dangerous drug as defined in section 4022 of the Code and a Schedule II controlled substance under Health and Safety Code section 11055(d)(6).

23. **Morphine sulfate** is a potent opioid analgesic. Morphine is a dangerous drug as defined in section 4022, a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code.

24. **Sinemet** is a trade name for a combination of carbidopa and levodopa. Sinemet is prescribed for the treatment of Parkinson's disease and syndrome. It is a dangerous drug as defined in section 4022. Sinemet is associated with dyskinesias and may cause mental disturbances. Patients should be observed carefully for the development of depression with concomitant suicidal tendencies.

25. **Soma** is a trade name for carisoprodol, a muscle-relaxant and sedative. It is a dangerous drug as defined in section 4022. Since the effects of carisoprodol and alcohol or carisoprodol and other CNS depressants or psychotropic drugs may be additive, appropriate caution should be exercised with patients who take more than one of these agents simultaneously.

26. **Phenergan** is a trade name for promethazine HCI. It is a dangerous drug as defined in section 4022. Phenergan has antihistaminic, sedative, antimotion-sickness, antiemetic, and anticholinergic effects. It may be used as a preoperative sedative. The concomitant use of alcohol, sedative hypnotics (including barbiturates), general anesthetics, narcotics, narcotic analgesics, tranquilizers or other central nervous system depressants may have additive sedative effects and patients should be warned accordingly. Phenergan may significantly affect the actions of other drugs. It may increase, prolong, or intensify the sedative action of central-nervous-system depressants.

27. **Valium** is a trade name for diazepam, a psychotropic drug for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code.

28. **Xanax** is a trade name for alprazolam. Alprazolam is a psychotropic triazolo analogue of the benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 and a Schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d) of the Health and Safety Code. Xanax has a central nervous system depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to habituation and dependence.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent's license is subject to discipline for unprofessional conduct in violation of section 2234, subdivisions (a) [Violating Provisions of this Chapter] and (b) [Gross Negligence],

in that his care and treatment of patient KC[1] included extreme departures from the standard of care. The facts are as follows:

30. As reflected in his medical records, Respondent first documented his evaluation of patient KC at the offices of Ampla Health on November 26, 2011. Respondent's chart entries of this visit includes an abbreviated history, noting only problems with anxiety, for which she takes benzodiazepines, and increasing restless leg syndrome. Respondent failed to document any social history or any history of alcohol or illicit drug use, and made no reference to any psychiatric treatment or history, although the record discloses that Respondent was aware that patient KC was or had been taking two antipsychotic medications. Respondent did not document the other prescription medications KC was currently taking. Respondent's physical examination was extremely limited. The initial assessment is "Back Pain by History," anxiety disorder, and restless leg syndrome. There was no recorded examination of the patient's spine or legs; her neurological condition is checked as "normal" with no additional neurological information obtained. Respondent's recorded treatment plan consisted entirely of an order for a spine X-ray and a list of medications he prescribed at this initial visit, including Klonopin and Vicodin.

31. At eight office visits with KC over the following year, Respondent also variously prescribed oxycodone, hydrocodone, morphine, and Soma. At none of these visits did Respondent document consideration or discussion of possible drug interactions or exacerbation of underlying psychiatric illness from the prescribed medications. The record does not contain an informed consent from the patient regarding treatment with opiate medications. Respondent's medical record for patient KC covering this year's treatment reflects a pattern of sparse documentation regarding the patient's history, inadequate physical examination, and lack of a specific treatment plan with objective goals.

32. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to obtain and document informed consent from patient KC for treatment with opiate

[1] Patient initials are used herein to maintain patient confidentiality. The patients' full names will be provided to Respondent in discovery.

medications is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

33. The allegations of paragraphs 30 and 31 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that diagnosing and purporting to treat anxiety disorder in patient KC without performing a sufficient social, substance use, psychiatric, and neurological history and without performing and documenting an adequate physical examination is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

THIRD CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

34. The allegations of paragraphs 30 and 31 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his prescribing of dangerous drugs to patient KC without performing an appropriate physical examination is a violation of section 2242, constituting unprofessional conduct.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

35. The allegations of paragraphs 30 and 31 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing to patient KC without documenting consideration of the potential for dangerous interaction of opiates, Soma, Risperdal, and Klonopin is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

36. The allegations of paragraphs 30 and 31 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his failure to maintain adequate and

accurate records relating to his care and treatment of patient KC is a violation of section 2226 constituting unprofessional conduct.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence)

37. Respondent's license is subject to discipline for unprofessional conduct in violation of section 2234, subdivisions (a) [Violating Provisions of this Chapter] and (b) [Gross Negligence], in that his care and treatment of patient DG included extreme departures from the standard of care. The facts are as follows:

38. Patient DG first saw Respondent at his medical office on August 9, 2011. Respondent's chart notes for this initial visit state that Respondent knew this patient from prior treatment at another facility. Respondent also notes that she was already being prescribed a high dose of OxyContin. At this initial visit, Respondent diagnoses DG as suffering from interstitial cystitis, chronic pain syndrome, and anxiety. Respondent prescribed Valium for DG, apparently based on the his observation that she appeared anxious and tearful. Respondent failed to document any consideration of whether Valium might dangerously interact with the high dose of OxyContin patient DG was receiving. Respondent did not document a history of anxiety, a substance use history, or any history of past treatment. Respondent's chart notes indicate that he ordered treatment records from her primary care physician but did not verify her treatment or prescriptions from other providers prior to undertaking treatment and prescribing to DG.

39. At an office visit just two weeks later, Respondent added fibromyalgia to his diagnoses. Respondent prescribed Morphine Sulfate IR (Immediate Release), Gabapentin, Phenergan, amitriptyline, and OxyContin in an amount 20% greater than she had been receiving. No informed consent for treatment with opiates is present in Respondent's records for patient DG.

40. In the course of more than a dozen office visits over the next 14 months, Respondent continued to prescribe--and even increase the dosage of—OxyContin to DG, despite notes in his own medical records that describe the amount of OxyContin she was receiving as "ridiculously high" and "unbelievable." Indeed, he was then prescribing an amount roughly 8 times the recommended maximum dose. At the November 17, 2011, office visit, Respondent increased the

prescription of morphine from 30 mg. twice daily to 30 mg. 4 times a day, with no documented rationale for the increase. On September 6, 2012, Respondent added Halcion to his prescriptions for patient DG. Nowhere in Respondent's medical record of DG's treatment did he document a patient history or an adequate physical examination that would justify the doses of benzodiazepines and opioid medications he prescribed to her.

41. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to obtain and document informed consent from patient DG for treatment with opiate medications is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

SEVENTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

42. The allegations of paragraphs 38 through 40 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his prescribing of dangerous drugs to patient DG without first performing an appropriate physical examination is a violation of section 2242, constituting unprofessional conduct.

EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence)

43. The allegations of paragraphs 38 through 40 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing a benzodiazepine to patient DG when she was receiving very large doses of opiate medication was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

NINTH CAUSE FOR DISCIPLINE

(Gross Negligence)

44. The allegations of paragraphs 38 through 40 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his continuing to prescribe extremely large doses of opiate medication to patient DG in the

absence of detailed records from other prior or contemporaneous providers was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

45. The allegations of paragraphs 38 through 40 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his failure to maintain adequate and accurate records relating to his care and treatment of patient DG is a violation of section 2226 constituting unprofessional conduct

ELEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

46. Respondent's license is subject to discipline for unprofessional conduct in violation of section 2234, subdivisions (a) [Violating Provisions of this Chapter] and (b) [Gross Negligence], in that his care and treatment of patient CM included extreme departures from the standard of care. The facts are as follows:

47. Patient CM first saw Respondent on November 29, 2010, for a two week post-operative checkup after bariatric surgery, in place of her primary care physician. At this first visit, Respondent documents a very brief history and physical examination, with no mention of back pain or anxiety. Although Respondent states that he is not, at that first visit, CM's primary care physician, he prescribes Norco and lorazepam to CM, with a referral to see her regular doctor in two weeks. There is no indication CM ever returned to her regular doctor.

48. At CM's next visit, on December 27, 2010, Respondent records a history that consists entirely of the entry: "Needs Rx norco, loraz. Her back pain is improving." No spine, neurological, or psychiatric examinations or referrals to specialists are noted. Over the next two years and in the course of more than 30 office visits, Respondent failed to note an appropriate patient history at any point and failed to perform and document an adequate physical examination but still prescribed copious amounts of benzodiazepines and opiate medications, including multiple short-acting opiates: e.g., Norco, Percocet, and oxycodone IR. The medical record does not contain documented inform consent from CM for the prescribing of opioids.

49. On May 24, 2011, patient CM presented to Respondent with a complaint of neck pain after a fall. Though he was aware that CM had undergone cervical spine surgery in the past, Respondent did not document the presence or absence of numbness, tingling, or bowel/bladder deficits, nor did he even document a physical examination of her spine. His neurological examination of CM for her complaint mentions only gait and strength. Respondent ordered a series of X-rays of her spine and prescribed 180 tablets of Norco 10/325, an approximately 50% dosage increase, as a "1 mo only" measure. This one time increase became a permanent feature in Respondent's prescribing regimen for CM, with no further explanation or rationale given in the medical record.

50. At his August 31, 2011, visit with CM, Respondent added Restoril to her prescriptions, without dose, frequency, or instructions documented in the record. Respondent was already prescribing lorazepam, another benzodiazepine, to CM. Less than one month later, Respondent added Klonopin to the mixture, a third benzodiazepine. On October 3, 2011, Respondent began prescribing Soma to CM, in addition to the Norco, Percocet, lorazepam, Klonopin, and Restoril she was already receiving. On December 19, 2011, Respondent added Ambien, a fourth benzodiazepine, to his prescribed medications for CM. Despite the fact that CM was seeking—and receiving-- early refills of her medications, claiming loss of the prior filled prescriptions there is no indication in the record that Respondent considered that CM might be misusing or diverting any of these medications.

51. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to obtain and document informed consent from patient CM for treatment with opiate medications is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWELFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

52. The allegations of paragraphs 47 through 50 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his failure to maintain

adequate and accurate records relating to his care and treatment of patient CM is a violation of section 2226 constituting unprofessional conduct.

THIRTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

53. The allegations of paragraphs 47 through 50 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing multiple benzodiazepines to patient CM simultaneously was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

FOURTEENTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

54. The allegations of paragraphs 47 through 50 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his prescribing of dangerous drugs to patient CM without first performing an appropriate physical examination is a violation of section 2242, constituting unprofessional conduct.

FIFTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

55. The allegations of paragraphs 47 through 50 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his continued prescribing of controlled substances well known as commonly inducing abuse to patient CM in the face of strong indications CM was misusing or diverting those medications without documenting a sufficient rationale for that prescribing or a plan to discontinue or taper the amounts and drugs given was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

SIXTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

56. Respondent's license is subject to discipline for unprofessional conduct in violation of section 2234, subdivisions (a) [Violating Provisions of this Chapter] and (b) [Gross Negligence],

in that his care and treatment of patient MC included extreme departures from the standard of care, as described below.

57. Patient MC first saw Respondent at the Oroville Family Health clinic on March 18, 2011. Prior medical records for MC at this clinic list scoliosis, PTSD, and depression among her complaints. At this first visit, Respondent notes MC is in for medication refill and complaints of possible urinary tract infection, moodiness and "quick temper." There was no record that Respondent took a detailed psychiatric or neurologic history, nor was there a physical examination documented apart from the note "Back tender to percussion Right flank area." Respondent's assessment was "UTI—early pyelo" and "scoliosis [with] back pain." Respondent prescribed antibiotics; morphine sulfate—extended release 110 mg.; Norco 10/235; and Soma 350 mg. to MC on this first visit. Respondent did not include a treatment plan nor acknowledgment of informed consent in MC's record.

58. MC saw Respondent again on June 13, 2011. At this second visit, Respondent charts a sparse history and states that MC's general appearance, lungs, and heart are normal. No musculoskeletal, neurological, or psychiatric examination is performed. Respondent's assessment is scoliosis with back pain, anxiety with possible bipolar disorder, and possible attention deficit hyperactivity disorder. Respondent refilled the prescriptions for morphine sulfate, Norco, and Soma, and added fentanyl 50 mcg/hr patches.

59. Respondent continued to see MC at intervals of approximately 3 weeks from June 13, 2011, through October 5, 2012. Over the course of those visits, Respondent frequently increased the dosage of the medications he prescribed to patient MC and changed the medications without clinical justification for those changes. Respondent did not maintain a detailed medication list for the medications he prescribed to MC. From the prescription record, it is known that Respondent also prescribed the benzodiazepines Phenergan and Ativan to MC while he was concurrently prescribing two long-acting and one short-acting opiates to her.

60. Respondent's notes from the October 2, 2011, office visit state that MC had been recently seen at a local hospital's emergency department; the discharge summary concluded: "altered mental status due to pain meds." No further history was noted. Respondent

discontinued the benzodiazepine Xanax which he had prescribed the month before to MC, but began her on Ativan, another benzodiazepine, in combination with the two long-acting and one short-acting opiates he had been prescribing for her. At the office visit on November 7, 2011, Respondent began prescribing the central nervous system stimulant Methylphenidate to MC, adding that medication to the morphine sulfate, fentanyl, and Norco regimen Respondent continued to prescribe to MC.

61. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to obtain and document informed consent from patient MC for treatment with opiate medications is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

SEVENTEENTH CAUSE FOR DISCIPLINE

(Prescribing Without Appropriate Examination)

62. The allegations of paragraphs 57 through 60 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his prescribing of dangerous drugs to patient MC without first performing an appropriate physical examination is a violation of section 2242, constituting unprofessional conduct.

EIGHTEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

63. The allegations of paragraphs 57 through 60 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing of multiple opiate and benzodiazepine medications concurrently to patient MC was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

NINETEENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

64. The allegations of paragraphs 57 through 60 above are incorporated herein by reference. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to recognize and appropriately respond to patient MC's emergency room admission for

medication-related altered mental status was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTIETH CAUSE FOR DISCIPLINE

(Gross Negligence)

65. Respondent's license is subject to discipline for unprofessional conduct in violation of section 2234, subdivisions (a) [Violating Provisions of this Chapter] and (b) [Gross Negligence], in that his care and treatment of patient BC included extreme departures from the standard of care, as described below.

66. While her medical record indicates that patient BC first saw Respondent on June 9, 2012, Patient BC had completed a Confidential Medical History Form on May 25, 2012, which was in her medical record and available to Respondent. The form was not signed as having been reviewed by any MD. On the form, BC indicates she was last seen for a physical examination by an MD in 2009. She listed Abilify, Zyprexa, Zoloft, Klonopin, Norco, Soma, and Remeron as her current medications. She stated her medical problems included diabetes, bronchitis, chronic sinus problems, emphysema, asthma, chest pain/angina, shortness of breath after mild exertion, joint pain, sickle cell, psychiatric problems, frequent severe headaches, numbness, hemophilia, anemia, ulcers, bowel trouble, glaucoma/vision changes, and family stressors. Questions on the form pertaining to alcohol and drug use were unanswered.

67. At BC's first visit with Respondent on June 9, 2012, Respondent checked the boxes for normal physical examination results generally, and for heart and lungs. He notes "CT neck (degenerative changes) C4-C7" but there is no documentation that Respondent examined BC's neck or shoulder. Respondent's assessment is neck pain, right shoulder pain, anxiety, and "can't sleep." Respondent's written treatment plan includes a referral for physical therapy and prescriptions for Soma, Klonopin, and morphine sulfate—extended release. The record does not contain an informed consent for opiate therapy, nor is there any documentation that Respondent discussed any alcohol or drug use with BC despite the fact BC had not responded to those areas of the Confidential Medical History form.

68. The next recorded treatment afforded patient BC was on July 11, 2012. There was no office visit but the record shows BC was prescribed Kadian 10mg, once per day, for neck and shoulder pain. The next actual office visit occurred on July 17, 2012 and was described as a follow-up for neck and shoulder pain. Respondent noted BC had not filled the prescription for morphine sulfate due to cost; Respondent also noted: "Pt getting Norco from Dr. Garretson." Respondent re-prescribed the Kadian, as well as Soma and Klonopin for patient BC at this visit.

69. Respondent noted BC's continuing shoulder and neck pain and anxiety at the next office visit on August 17, 2012. Noting that "Kadian 10s did nothing", Respondent increased the dosage of Kadian to 20 mg twice per day—a 400% increase--and began prescribing Ambien for her.

70. At the next office visit with BC on September 14, 2012, Respondent first documents a physical examination of BC's shoulder, finding her "unable to abduct R arm to 90 degrees." Respondent orders a shoulder X-ray and an orthopedic referral. The prescriptions for Kadian, Klonopin, and Soma are refilled; the record contains no mention of the Ambien prescription issued at the prior visit.

71. Patient BC next presented to Respondent on October 13, 2012. Respondent charted BC's wheezing; no pulse, temperature, or respiratory rate noted. The orthopedic referral was still awaiting the ordered shoulder X-rays. Respondent's assessment of BC on this visit included upper respiratory infection and continuing shoulder pain. Respondent adds a prescription for Phenergan with codeine to the continuing prescriptions for Kadian and Klonopin.

72. Patient BC's last recorded visit with Respondent occurred 10 days later. He noted her respiratory function was now normal, that her shoulder pain was ongoing, and that "Kadian 20 mg not lasting very long." BC evidently told Respondent she took her daughter's prescribed Sinemet and found it helpful. Sinemet is a medication prescribed to treat Parkinson's disease; nothing in BC's medical record indicates she suffers from Parkinson's disease. Respondent added Sinemet to the prescriptions he wrote for BC, increasing the Kadian to 30 mg twice daily and continuing the Klonopin.

73. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to obtain and document informed consent from patient BC for treatment with opiate medications is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

74. The allegations of paragraphs 66 through 72 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to document review of the unanswered questions regarding alcohol and drug abuse on her Confidential Medical History form prior to his prescribing opiate medication to patient BC was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

75. The allegations of paragraphs 66 through 72 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing of long acting opiate medication in combination with Soma and Klonopin to patient BC was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

76. The allegations of paragraphs 66 through 72 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing Phenergan to BC concurrent with escalating doses of opiate and benzodiazepine medications was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

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TWENTY-FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

77. The allegations of paragraphs 66 through 72 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing Ambien to BC concurrent with Klonopin, Soma, and a long-acting opiate medication was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence)

78. The allegations of paragraphs 66 through 72 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing Sinemet to patient BC for an off label indication without documenting the clinical indication and the rationale for this drug was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

79. The allegations of paragraphs 66 through 72 above are incorporated herein by reference. Respondent has subjected his license to discipline in that his failure to maintain adequate and accurate records relating to his care and treatment of patient BC is a violation of section 2226 constituting unprofessional conduct.

TWENTY-SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence)

80. Respondent's license is subject to discipline for unprofessional conduct in violation of section 2234, subdivisions (a) [Violating Provisions of this Chapter] and (b) [Gross Negligence], in that his care and treatment of patient DV included extreme departures from the standard of care, as described below.

81. Respondent first saw patient DV on March 7, 2011. DV had been seen previously by other providers at the same medical clinic and those records were available to Respondent. At

the first visit, Respondent's chart notes indicate that DV was being seen for continuing left side abdominal pain and that she had a history of pancreatitis. Respondent's clinical history for DV includes meth use, alcoholism, depression, and possible bipolar disorder. Respondent also notes that "she and her previous doctor did not agree on her pain med needs." The chart contains no gastrointestinal review of systems. The notes pertaining to a physical examination are sparse. There is no documentation of any questions or discussion of alcohol use or substance abuse. There is no informed consent regarding treatment with opiate therapy. Respondent's assessment is left-sided abdominal pain, depression, chronic obstructive pulmonary disease; he further notes that her abdominal pain is chronic and she has been taking anti-spasmodics for years. He prescribed Vicodin 5/500, 3-4 times daily; donnatal (an anti-spasmodic containing a mix of medications, including the barbiturate phenobarbital); Phenergan, Zoloft (an anti-depressant), and busiprone for anxiety.

82. Patient DV next saw Respondent on March 16, 2011. Respondent's assessment is that DV is suffering from a urinary tract infection, abdominal pain, and depression; he orders an abdominal ultrasound and an H.pylori assay. Respondent also prescribed Percocet 5/325 and the antibiotic Keflex.

83. The medical records for DV's office visit on March 29, 2011, note that she was seen in the emergency department for abdominal pain 5 days prior; the clinical evaluation by the emergency department was reportedly inconclusive. The test results for H.pylori were negative. Respondent prescribed Norco 10/325 and Valium 10 mg. for DV on this visit.

84. Between March 29, 2011 and their final office visit on September 18, 2012, patient DV saw respondent at his office for 12 additional visits. Respondent's progress notes for these visits do not include the medication dosages. Respondent's records do not contain a medication list of the drugs prescribed, which included Vicodin, Phenergan, a compound containing a barbiturate; an antidepressant; busiprone, Percocet, Valium, Klonopin, and Norco at various points and combinations. On July 21, 2011, Respondent's physician assistant noted DV's cannabis use. Despite this information and the knowledge that DV had a history of methamphetamine use, at no point in the 18 month period in which he was treating her did

Respondent order a toxicological screening for DV. A urine toxicological screen administered 10 weeks after her last visit with Respondent was positive for opiates, cannabis, amphetamine, and methamphetamine.

85. Respondent has subjected his license to discipline for unprofessional conduct in that his failure to secure an adequate clinical history before prescribing controlled substances or to order toxicological screening during his course of treatment of a patient with a known history of alcohol and methamphetamine abuse is an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-EIGHTH CAUSE FOR DISCIPLINE

(Gross Negligence)

86. The allegations of paragraphs 81 through 84 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline for unprofessional conduct in that his prescribing opiates, benzodiazepines, a barbiturate, Soma, and Phenergan to DV without documenting the clinical justification for the doses, frequency, and combination of these drugs was an extreme departure from the standard of care, constituting gross negligence in violation of section 2234(b).

TWENTY-NINTH CAUSE FOR DISCIPLINE

(Failure to Maintain Medical Records)

87. The allegations of paragraphs 81 through 84 above are incorporated by reference as if set out in full. Respondent has subjected his license to discipline in that his failure to maintain adequate and accurate records relating to his care and treatment of patient DV is a violation of section 2226 constituting unprofessional conduct.

CAUSE TO REVOKE PROBATION

(Violation of Laws)

88. At all times after the effective date of the commencement of Respondent's probation, Condition Eight of the terms of probation required that Respondent obey all laws, expressly including the rules governing the practice of medicine in California.

89. Respondent's probation is subject to revocation because he failed to comply with Probation Condition Eight in that each of the Causes for Discipline presented herein constitute a separate and sufficient violation of the rules which govern the practice of medicine in California.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking the probation that was granted by the Medical Board in Case No. D1-2005-164954 and imposing the disciplinary order that was stayed, thereby revoking Physician's and Surgeon's Certificate No. G40574 issued to Dirk Hendrik Van Meurs, M.D.;

2. Revoking, suspending, or denying approval of Dirk Hendrik Van Meurs, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Dirk Hendrik Van Meurs, M.D., if placed on probation, to pay the Medical Board of California the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 20, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

Exhibit A

Decision and Order

Medical Board of California Case No. D1-2005-164954

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against:	)	
	)	**Case No. D1-2005-164954**
DIRK HENDRIK VAN MEURS, M.D.	)	
Physician and Surgeon's Certificate No. G 40574	)	
Petitioner.	)	

ORDER DENYING PETITION FOR RECONSIDERATION

The Petition filed by Dirk Hendrik Van Meurs, M.D. for reconsideration of the decision in the above-entitled matter having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on **July 19, 2010.**

IT IS SO ORDERED July 19, 2010.

MEDICAL BOARD OF CALIFORNIA

By: _____
Hedy Chang, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against:	)	
DIRK HENDRIK VAN MEURS, M.D.	)	File No. D1-2005-164954
Physician's and Surgeon's Certificate No. G 40574	)	
Respondent.	)	

DECISION

The attached Proposed Decision and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 19, 2010.

IT IS SO ORDERED June 17, 2010.

MEDICAL BOARD OF CALIFORNIA

By: _____
Hedy Chang, Chair
Panel B

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition to Revoke Probation Against: DIRK HENDRIK VAN MEURS, M.D. Albany, California Physician's & Surgeon's Certificate No. G 40574 Respondent.	Case No. D1-2005-164954 OAH No. 2009120552

PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on March 11, 2010, in Oakland, California.

Susan K. Meadows, Deputy Attorney General, represented Complainant Barbara Johnston, Executive Director of the Medical Board of California.

Respondent Dirk Hendrik Van Meurs, M.D., represented himself.

The record was originally left open until April 30, 2010, to allow Respondent to submit proof of completion of a PACE (Physician Assessment and Clinical Education) program. On May 4, 2010, the proof was received. As Ms. Meadows did not object, the record was re-opened to allow submission of the documents, which were marked and admitted into evidence as Exhibit C.

The record closed on May 4, 2010.

FACTUAL FINDINGS

1. Complainant Barbara Johnston issued the Petition to Revoke Probation in her official capacity as Executive Director of the Medical Board of California (Board).

2. On August 13, 1979, the Board issued Physician's and Surgeon's Certificate No. G 40574 to Dirk Hendrik Van Meurs, M.D. (Respondent). Respondent's certificate will expire on June 30, 2011, unless renewed.

3. In a Decision effective October 15, 2007, the Board revoked Respondent's certificate, stayed the revocation, and placed it on probation for five years. The Decision followed a stipulated settlement, wherein Respondent acknowledged that a prima facie case could be proven that he committed repeated negligent acts and/or unprofessional conduct in connection with the treatment of 13 patients. The conduct primarily concerned prescribing practices. The terms and conditions of probation required that Respondent complete a clinical training program and a prescribing practices course within 60 days. The 2007 Decision is attached as Exhibit A and incorporated in full by this reference.

4. Complainant contends that Respondent's probation is subject to revocation because he failed to comply with two conditions of probation: Condition 1 and Condition 17. In pertinent part, Condition 1 states:

> Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California – San Diego School of Medicine ("Program").
>
> The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill an judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment . . . .
>
> [¶] . . . [¶]
>
> At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Programs' determination whether or not Respondent passed the examination or successfully completed the Program shall be binding. Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

5. Condition 17 provides:

> Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs

shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

Respondent's probation compliance

6. On November 28, 2007, Respondent met with probation monitor Tony Tobin and they discussed the requirements of Respondent's probation. These included that he enroll in the PACE program within 60 days and complete it within six months from the date of enrollment unless the requirements were waived in writing.

7. On December 28, 2007, Tobin received a letter from PACE case manager Aaron Alverson that confirms receipt of Respondent's application and a portion of the processing fee. Alverson advised Respondent of the additional documents he needed to provide and of the remaining balance that needed to be paid before he could enroll in the program.

8. On July 2, 2008, probation monitor Brian Junger met with Respondent. They discussed Respondent's progress on probation. Respondent advised that he had enrolled in the PACE prescribing course to be held July 21 to 23, 2008. He had not yet enrolled in the clinical course because PACE required that the $7,000 fee be fully paid in advance. Respondent also advised Junger that he was experiencing financial difficulties due to a contentious divorce. Junger advised Respondent that the deadline had already been extended until September 15, 2008, and that Respondent needed to meet that deadline.

9. In September 2008 Arlene Caballero took over as Respondent's probation monitor. She and Junger met with Respondent on September 18, 2008. At the meeting, Respondent told them that he had sent in the remaining balance and paperwork for PACE's clinical training program "last week."

10. On February 24, 2009, Caballero spoke with case manager Alverson on the telephone. Alverson advised her that Respondent had not completed his enrollment package with PACE and so he had not been scheduled to attend the program. Specifically, Respondent had not submitted seven sample charts and a list of the patients he had seen in the prior month. Alverson advised that he had contacted Respondent on several occasions about these matters, but to no avail.

On the same date, Caballero met with Respondent. She advised him to send the information to PACE. He did not tell her why he had not done so.

11. On June 12, 2009, Caballero issued a non-compliance report which notes that Respondent had not sent the required documents and payments to PACE. Respondent told Caballero that he had not completed his enrollment because of financial reasons. Caballero warned Respondent that "his livelihood was at risk" if he did not comply.

12. Caballero also sent letters to Respondent informing him that he was in violation of the probation condition that he pay probation monitoring costs according to a set schedule.

13. After the Petition to Revoke Probation was filed, Respondent completed his enrollment with PACE. As of the hearing date, he had completed both Phase I and Phase II; however, he only completed Phase II the week before the hearing and the results had not been determined. On April 29, 2010, PACE issued a Certification of Completion of a 40-hour intensive training program in Family Medicine to Respondent.

14. It was established that Respondent has satisfied all of the educational requirements of his probation; however, as he did not do so within the required time frame, he violated Condition No. 1.

15. It was established that Respondent violated Condition 17, in that he failed to timely pay probation monitoring costs of $2,909. That sum was due on January 31, 2009. The record does not reveal what balance, if any, is currently owed.

Respondent's explanations

16. Respondent admits that he engaged in inappropriate prescribing when he got "caught up in a clinical situation [he] was not prepared for." But he took the practice deficiencies he was charged with very seriously and asserts that he has corrected those deficiencies. Respondent is now employed as a family practitioner in a small office. He is the only full-time doctor in the clinic, and is required to do his own paperwork and paperwork for the part-time doctors. Respondent describes the clinic as a "wonderful place to work," but this experience has been overwhelming and he was unable to get the paperwork together for PACE in a timely manner.

Primarily, however, Respondent's failure to timely complete the PACE program and pay the costs as ordered were due to extreme financial difficulties. As of February 20, 2010, Respondent calculates that the Decision required he pay $13,700 for PACE, $3,173 per year for probation monitoring and $1,800 per year for practice monitoring. Although his income is approximately $200,000 annually, given his family circumstances, including varying levels of support of five children and the legal costs of his divorce, Respondent has found it very difficult to make the required payments.

17. Respondent regrets his failure to pay the costs as required. Presently, although he still has payments to make in connection with his divorce and back taxes, his financial situation has stabilized. He anticipates the ability to comply with the financial requirements of probation in the future.

LEGAL CONCLUSIONS

1. Cause for revocation of probation exists by reason of Respondent's violation of Condition 1: failure to complete the required educational courses in the time required. (Findings 6 through 11, 13, and 14.)

2. Cause for revocation of probation exists by reason of Respondent's violation of Condition 17: failure to pay costs to the Board as required. (Findings 12 and 15.)

Discussion

3. As two probation violations have been established, it remains to determine the appropriate consequence. The Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines sets forth recommended dispositions. The recommended minimum discipline for probation violations is a 30-day suspension and the maximum is revocation of probation. Also relevant here is Business and Professions Code, section 2229, subdivision (b), which provides that the Board shall, wherever possible, "take action that is calculated to aid in the rehabilitation of the licensee" and subdivision (a), which states that public protection is the "the highest priority."

The underlying matter in this case concerned a failure of practice that Respondent has consistently acknowledged. He has completed two educative courses designed to remediate the deficiencies. Respondent's lack of diligence in complying with all of the conditions of probation is of concern, but revocation of his certificate is not warranted at this time. It is concluded that the public interest will be sufficiently protected by a term of probation pursuant to slightly revised conditions, extending an additional year, and including a 30-day suspension of his certificate. As the original probation term would have expired on August 28, 2012, the new probation term will be for three years.

ORDER

The Petition to Revoke Probation concerning Physician's and Surgeon's Certificate No. G 40574, issued to Respondent Dirk Hendrik Van Meurs, M.D., is granted. The stay is lifted and the certificate is revoked; however, the revocation is stayed and Respondent is placed on probation for three years pursuant to the following terms and conditions:

1. Suspension

   Respondent's certificate is suspended for 30 days.

2. Practice Monitor

   Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice

monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decisions, Accusation, and Petition to Revoke Probation, and a proposed monitoring plan. Within 15 calendar days of receipt of these documents, the monitor shall submit a signed statement that the monitor has read the documents, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's prescribing practices shall be monitored by the approved monitor. As part of the monitoring plan, the monitor shall review, at random, a minimum of five patient records prior to the submission of every quarterly written report to the Board. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after

being so notified by the Board or designee.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

3. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.

4. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient

practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

5. Notification

Prior to engaging in the practice of medicine the Respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

6. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

7. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

10. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

11. Residing or Practicing Out-of-State

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However, Respondent's license shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

12. Failure to Practice Medicine - California Resident

In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an

Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: May 20, 2010

MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings